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ABSTRACT

Finding effective treatment models for youth in the juvenile justice system with serious emotional, mental health, and behavioral needs can be difficult. The traditional categorical approach that the juvenile justice, child welfare, and mental health systems often use places youth in a "one-size-fits-all" program, regardless of the youth's needs. Wraparound Milwaukee takes a quite different approach. This approach, which is based on the Wraparound philosophy, offers care that is tailored to each youth. The following elements of the Wraparound approach have been found to be of particular importance when working with children in the juvenile justice system: a strength-based approach to children and families; family involvement in the treatment process; needs-based service planning and delivery; individualized service plans; and an outcome-focused approach. This program, which began in 1994, is made up of the following components: care coordination; the Child and Family Team; a mobile crisis team; and a provider network. Because Wraparound Milwaukee blends system funds, it can provide a flexible and comprehensive array of services to delinquent youth and their families. While this program offers many formal services, informal services that the care coordinator and Child and Family Team identify through strengths assessment are often even more effective. Outcomes for youth participating in Wraparound Milwaukee have been encouraging. Data indicate that the program is achieving positive outcomes. The challenges and the future of this program are briefly discussed. (MKA)

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Wraparound Milwaukee: Aiding Youth With Mental Health Needs

by Bruce Kamradt

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The estimated percentage of youth with mental health disorders in the juvenile justice system varies from study to study. Estimates of diagnosable mental health disorders among the general population run about 20 percent. While there are no reliable national studies of the prevalence of mental health disorders among juvenile offenders, estimates from existing studies indicate that the rate for mental health disorders among juvenile offenders may be as high as 60 percent, of which an estimated 20 percent have severe mental health disorders (Cocozza, 1992).

Finding effective treatment models for youth in the juvenile justice system with serious emotional, mental health, and behavioral needs can be difficult. Systems tend to use more traditional residential and day treatment programs to serve these youth. The traditional categorical approach that the juvenile justice, child welfare, and mental health systems often use places youth in a "one-size-fits-all" program, regardless of the youth's needs.

Wraparound Milwaukee, now in its fifth year of operation, takes a quite different approach to serving youth with mental health needs. The program serves more than 650 youth, 400 of whom are adjudicated delinquent. Created under a Center for Mental Health Services grant, Wraparound Milwaukee sustains itself by pooling dollars with its systems partners and taking an integrated, multiservice approach to meeting the needs of youth and their families. This approach, which is based on the Wraparound philosophy and the managed care model, offers care that is tailored to each youth. Data indicate that the program is achieving positive outcomes.

Process and Approach

The Wraparound philosophy began with John Brown, a Canadian service provider who developed the idea of placing youth in small group homes with individualized care, flexible programming, and a "never

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give up" philosophy (Behar, 1985). Karl Dennis' Kaleidoscope program in Chicago, IL, and John Van Den Berg's Alaska Youth Initiative adapted these concepts. The Kaleidoscope program—the oldest Wraparound initiative in the United States—used unconditional care and flexible, integrated services to meet youth and family needs (Burns and Goldman, 1998). The Alaska Youth Initiative used cross-system collaboration and funding and individualized planning to bring youth back to the community from out-of-State residential treatment placements (Burchard et al., 1993). Dr. Ira Laurie, National Director of the U.S. Department of Health and Human Services' Child and Adolescent Services System Program (CASSP), further conceptualized the process. His descriptions of the values of CASSP in treating children with serious emotional problems, including the development of individualized, child-centered, family-focused, community-based, and culturally competent services, have been adopted by Wraparound (Laurie and Katy-Leavy, 1987).

The evolution of Wraparound in systems design was further enhanced by the implementation and growth of system of care models, developed under demonstration grants from the U.S. Department of Health and Human Services' Center for Mental Health Services. This grant program incorporated the values, philosophy, and approaches of Wraparound to promote integrated service systems for youth with serious emotional problems operating across the mental health, juvenile justice, child welfare, and education systems.

Although there are many components to Wraparound, the following elements have been of particular importance in working with children in the juvenile justice and child welfare systems:

Demographics of the Delinquent Population in Wraparound Milwaukee

- Eighty percent are male.
- The average age is 14.7.
- Sixty-five percent are African American, 28 percent are Caucasian, and 7 percent are Hispanic.
- Sixty-five percent are from mother-maintained households.
- Fifty-three percent of the population's families are at or below the poverty level.

◆ **Strength-based approach to children and families.** Mental health and juvenile justice systems have focused largely on identifying a child's deficits or a family's problems. This is not the most effective way to engage a child or family in the treatment process. Focusing on a family's strengths, learning about the family's culture, and building on the natural supports that exist within the family, neighborhood, or community is a much more effective approach. Examples of such supports include peer groups, recreational basketball leagues, parenting classes, and positive relationships a child may have with grandparents, uncles, aunts, peers, and others.

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◆ **Family involvement in the treatment process.** Families are the most important resource in any youth's life. Juvenile justice, child welfare, and mental health practitioners often have been too quick to identify families as the source of the youth's problems. The tendency is to remove youth from the home and institutionalize them in order to "fix" them. Youth, however, usually prefer to live with their families. Whenever possible, service providers should engage families in the treatment process. Accordingly, it is important that providers view families as capable and knowledgeable about their children's needs and enhance families' abilities to parent their troubled children.

Treatment plans that are tailored to address the unique needs of each child work best.

◆ **Needs-based service planning and delivery.** If families are to be involved as active partners, it is essential to listen to their assessment of their needs. Juvenile justice, child welfare, and mental health practitioners tend to assume that as "experts" they are best equipped to decide the programs and services youth need. If, for example, a youth and family have identified a need for respite care, a tutor, or a mentor to serve as a positive role model, why do some practitioners insist on providing outpatient therapy, day treatment, or residential care? The failure to listen to what a child and family identify as their needs, and to address those needs, can cause programs and services to fail.

◆ **Individualized service plans.** Treatment plans that are tailored to address the unique needs of each child and family work best. Individualized plans for youth, particularly those involved in the juvenile justice system, must address the typical needs of persons of like age, gender, or culture. These can involve living situations; legal status; and medical, health, and psychological needs.

◆ **Outcome-focused approach.** The Wraparound process does not rely on subjective assessments of what does or does not work. Clear goals for the youth and family—established by the youth and family in partnership with the professionals—are continually measured and evaluated. The key to this approach is to manage the process to ensure desired outcomes.

Implementation

Wraparound Milwaukee adapted the Wraparound process to its system of care in some very unique ways. In Milwaukee, the multiple needs of youth who cross juvenile justice, child welfare, and mental health system lines are coordinated through a public managed care organization. Youth and families are offered enrollment in a type of social/medical health maintenance organization (HMO) with a comprehensive benefit plan that offers more than 60 services. These services are individualized for each youth and family, based on their identified needs.

History

Wraparound Milwaukee is part of the Milwaukee County Human Services Department, Milwaukee County Mental Health Division, which provides juvenile probation and child welfare services. In 1994, Milwaukee County received a 5-year Federal grant from the Center for Mental Health Services to initiate system reform in the community. Although Wraparound Milwaukee experienced initial success in providing services to youth and families in the mental health system, it was not until it targeted youth in the child welfare and juvenile justice systems that it demonstrated the effectiveness of the

Wraparound approach with youth who have multiple needs.

In May 1996, Wraparound Milwaukee initiated a pilot project, The 25 Kid Project, to use Wraparound philosophy with both delinquent and nondelinquent youth placed in residential treatment centers. Prior to this project, child welfare and juvenile justice placements had reached record proportions—more than 360 youth were in placement on an average day at a cost of more than $18 million per year. Wraparound Milwaukee targeted 25 youth in residential treatment centers, identified by child welfare and juvenile justice professionals, who had no immediate discharge plans. The goal was to demonstrate that by using a Wraparound model most of these youth could be returned home or to community-based foster or kinship care, that they could be maintained safely in those settings, and that it would cost less than a residential placement. Within 90 days, Wraparound Milwaukee returned 17 of the youth to the community. Eventually, 24 of the 25 youth were placed in the community. Seven youth entered foster homes; the remaining 17 successfully returned to their families.

Key Components

The structural and design aspects of Wraparound incorporate components of care that are integrated to meet the specific needs of each child and family. The following components are essential to the success of the project:

◆ **Care coordination.** Care coordinators are the cornerstone of the system. They perform strength-based assessments, assemble the Child and Family Team, conduct plan-of-care meetings, help determine needs and resources with the youth and family, assist the team in identifying services to meet those needs, arrange for community agencies to provide specific services, and monitor the implementation of the case plan. Care coordinators in the Wraparound Milwaukee Project typically work with small caseloads (a ratio of one worker to eight families), which provides more time for the personal contact needed to work with youth with complex needs.

◆ **The Child and Family Team.** Wraparound plans are family driven. The care coordinator asks the family to identify all those who are providing support to the family. With this information, the care

Mental Health Issues of the Population in Wraparound Milwaukee

◆ **Predominant diagnoses when using the *Diagnostic and Statistical Manual of Mental Disorders: Fourth Edition, DSM–IV*** (American Psychiatric Association, 1994). Ninety-seven percent conduct disorder/oppositional defiant, 58 percent depression, 44 percent attention deficit, and 42 percent serious alcohol and substance abuse problems.

◆ **Primary identified concerns at intake for youth.** Fifty-two percent school/community, 40 percent acting out, 37 percent alcohol and substance abuse, and 33 percent severe aggressiveness.

◆ **Attempted suicide.** One in eight youth.

◆ **Primary family concerns at intake.** Fifty percent of parents have significant abuse issues, 33 percent of parents have a history of domestic abuse, 24 percent of parents have been incarcerated, and 22 percent of families have documented mental illness.

coordinator assembles the family members; the family's natural supports such as relatives, church members, and friends; and systems people, including probation or child welfare workers. These individuals form the core of the support system for the child and family.

◆ **A mobile crisis team.** To meet the needs of youth and families when a care coordinator might not be available, 24-hour crisis intervention services are available through the Mobile Urgent Treatment Team. The team consists of psychologists and social workers trained in intervening in family crisis situations that might otherwise result in the removal of youth from their home, school, or community. Youth participating in Wraparound are automatically enrolled in this crisis service, and their care plans include a crisis safety plan that the team can immediately access. The Mobile Urgent Treatment Team reviews all requests for inpatient psychiatric hospital admissions and operates two 8-bed group homes that provide short-term (up to 14 days) crisis stabilization. The crisis team and care coordinator work with the family to return the child to the community. Because of the crisis team's availability, Wraparound Milwaukee has nearly eliminated the use of inpatient psychiatric care for most youth in the project.

◆ **A provider network.** Wraparound Milwaukee has an array of services and resources to respond to the multiple needs identified by families. This enables the program to move beyond the few categorical services historically prescribed for youth and families. As a result, Wraparound has expanded its portfolio of services from 20 to 60. Practitioners provide services on a fee-for-service basis, with Wraparound setting the price of each category of service. Rather than creating fixed-price contracts, vendors apply to provide one or more of the services as part of a provider network. The provider network now includes more than 170 agencies, a number that allows for a diverse list of providers and increases the choices families have when selecting agencies in the network from which to receive services.

Managed Care and Blended Funding

Because Wraparound Milwaukee blends system funds, it can provide a flexible and comprehensive array of services to delinquent youth and their families. Wraparound Milwaukee pools funds through case rates paid by the child welfare and juvenile justice systems, receives a monthly capitation payment for each Medicaid child enrolled, and coordinates other insurance and Supplemental Security Income payments to form a type of insurance pool. In 1999, Wraparound Milwaukee received more than $26 million in pooled funds. The child welfare and juvenile justice systems fund Wraparound at $3,300 per month per child. Prior to Wraparound, these funds were used entirely for residential treatment care for which the systems paid $5,000 or more per month per child. The $1,542 per month per child capitation payment from Medicaid covers the projected cost for all mental health and substance abuse services and is based on pre-Wraparound actuarial costs for services for these youth.

After all funds are pooled and decategorized, Wraparound Milwaukee can use them to cover any services that families need. Wraparound offers the same range of services to all enrolled families and covers any costs that exceed the pooled funds.

Informal Services

While Wraparound Milwaukee offers an array of formal services to youth and

their families, informal services that the care coordinator and Child and Family Team identify through strengths assessment are often even more effective. The Wraparound care plan, therefore, should use a mix of formal and informal services. One family may identify a friend or relative whose positive relationship with the youth indicates suitability as a mentor. Another family may identify a relative to provide respite care to the parent. These supports will remain with the family beyond their enrollment in Wraparound Milwaukee. Other examples of informal supports are a neighbor who provides transportation, a local church with a peer support group, or a YMCA program that offers recreation and summer camp programs. These services often can be mobilized at little cost and offer the advantage of always being there for the youth and family in their own community.

Outcomes

Outcomes for youth participating in Wraparound Milwaukee have been encouraging. The use of residential treatment has decreased 60 percent since Wraparound Milwaukee was initiated (from an average daily census of 364 youth in placement to fewer than 140 youth). Inpatient psychiatric hospitalization has dropped by 80 percent; in 1998, only 322 days of care were provided. As mentioned above, the average overall cost of care per child has

Services in the Wraparound Milwaukee Benefit Plan

- Care Coordination
- In-Home Therapy
- Medication Management
- Outpatient—Individual Family Therapy
- Alcohol/Substance Abuse Counseling
- Psychiatric Assessment
- Psychological Evaluation
- Housing Assistance
- Mental Health Assessment/ Evaluation
- Mentoring
- Parent Aide
- Group Home Care
- Respite Care
- Child Care for Parent
- Tutor
- Specialized Camps
- Emergency Food Pantry
- Crisis Home Care
- Treatment Foster Care
- Residential Treatment
- Foster Care
- Day Treatment/Alternative School
- Nursing Assessment/Management
- Job Development/Placement
- Kinship Care
- Transportation Services
- Supervision/Observation in Home
- Afterschool Programming
- Recreation/Child-Oriented Activities
- Discretionary Funds/Flexible Funds
- Housekeeping/Chore Services
- Independent Living Support
- Psychiatric Inpatient Hospital

dropped from more than $5,000 per month to less than $3,300 per month. Because the savings have been reinvested into serving more youth, the project now serves 650 youth with the same fixed child welfare/juvenile justice monies that previously served 360 youth placed in residential treatment centers.

Clinical outcomes, as measured by the Child and Adolescent Functional Assessment Scale (CAFAS) (Hodges, 1994), have improved significantly for delinquent youth. CAFAS is used in all Children's Mental Health Services programs to measure changes in the youth's functioning at home, at school, and in the community. With CAFAS, a lower score indicates the youth is functioning more adequately. For a group of 300 delinquent youth enrolled in Wraparound Milwaukee, the average score at the time of enrollment was 74, which is considered in the high range of impairment. By 6 months after enrollment, the average score decreased to 56, in the moderate range of impairment. One year after enrollment, the average score was 48, again a moderate level of impairment.

The reduction in recidivism rates for a variety of offenses for delinquent youth enrolled in Wraparound Milwaukee has been even more encouraging. Data were collected for a period of 1 year prior to enrollment in the project and 1 year following enrollment by the county's Child and Adolescent Treatment Center. The center reviewed court records for 134 delinquent youth enrolled in Wraparound. Table 1 shows the breakdown of the proportion of children committing each type of offense.

The reduction in these reoffense patterns is statistically significant. Although more focused studies on recidivism are needed, the results to date are promising. Continued studies of these youth 2 years following enrollment are planned so the long-range effects of Wraparound can be measured.

Table 1: Recidivism Rates of Delinquent Youth Enrolled in Wraparound Milwaukee (*n*=134)

Offense	1 Year Prior to Enrollment*	1 Year Post Enrollment**
Sex offenses	11%	1%
Assaults	14	7
Weapons offenses	15	4
Property offenses	34	17
Drug offenses	6	3
Other offenses†	31	15

* Seybold, E. Child and Adolescent Treatment Center. Child and Adolescent Functional Assessment Scale and Child Behavior Checklist (Achenbach and Edelbrock, 1980) data collected and analyzed through July 1999.

** Seybold, E. Child and Adolescent Treatment Center. Data collected and analyzed as of September 1999.

† Primarily disorderly conduct not involving use of a weapon.

Wraparound Milwaukee Case Studies

Michael, a 15-year-old Hispanic, was referred to Wraparound Milwaukee as the result of delinquency charges of party to a crime and attempted arson of a school building. As a result of the charges, Michael was expelled from a Milwaukee public school, and the Probation Department was ready to recommend residential treatment.

Michael is cognitively delayed and has received special education services. At one point, he had a substance abuse problem and was diagnosed with depression.

Michael's Child and Family Team included his mother, grandmother, a mentor, a teacher, a probation worker, and an alcoholism treatment counselor. The team worked on Michael's identified academic needs. They learned that he had poor vision, which contributed to his school problems. Michael enrolled in a specialized learning center to develop his academic skills. Initial testing by the learning center revealed that Michael tested at only a first- and second-grade level in English, mathematics, and reading. After 4 months, he improved his academic performance by two grades.

Michael's mentor introduced him to recreational and other activities and became a positive role model and father figure. Michael's grandmother provided respite care to Michael's mother once a week. Informal service providers included the Council for the Spanish Speaking, which provides substance abuse counseling, and Milwaukee Christian Center and Journey House, which offers neighborhood recreation activities.

After 1 year in Wraparound, Michael has been readmitted to his Milwaukee public school as a freshman and placed in a special education program. He now tests at a fifth- and sixth-grade level in English, mathematics, and reading—an extraordinary improvement. Michael has had no further delinquencies.

Anthony, a 15-year-old African American, originally was placed in Wraparound Milwaukee because of multiple counts of criminal damage to property. He was diagnosed with attention deficit disorder and major depression. Anthony's family strengths included his parents' desire to keep him at home, the number of aunts and uncles who were interested in being resources for him in times of family stress, and his family's motivation for change. Anthony's personal strengths included his outgoing nature, affection for his siblings, desire to find a job, and love for his parents.

His Child and Family Team included his mother, stepfather, aunt, a sibling, an in-home therapist, a probation worker, a volunteer mentor, and his care coordinator. Formal services he received through Wraparound included in-home treatment, day treatment, mentoring, and job coaching. Anthony's aunt provided informal services—Anthony would stay with her during some of his crisis periods.

Anthony has been in Wraparound for 2 years. He has had no further law violations and has been an honor student in the alternative school program. He is returning to a Milwaukee public high school. He is also working with an employment agency in the provider network to obtain a part-time job.

Challenges

Wraparound Milwaukee is proving to be an effective model that can be replicated in other communities. It is important, however, to note the challenges to system collaboration that care coordinators and case managers face. Table 2 outlines these challenges and the solutions that these professionals implement when working across systems.

Wraparound's Future

The future of Wraparound Milwaukee as an effective approach to meeting the needs of youth with serious emotional, behavioral, and health issues in the juvenile justice or child welfare systems remains positive.

Milwaukee's community has adopted the model designed for early intervention services for abused and neglected children in the child welfare system.

Table 2: Challenges to System Collaboration

Challenge	Solution
Operating with different terminology (juvenile court and mental health system).	◆ Cross train. ◆ Share each other's turf.
Defining roles (Who's in charge?).	◆ Conduct team development training. ◆ Conduct job shadowing sessions. ◆ Share myths and realities.
Sharing information.	◆ Set up a common database. ◆ Share organization charts and phone lists. ◆ Share paperwork. ◆ Promote flexibility in schedules to support attendance at meetings.
Addressing issues of community safety.	◆ Document safety plans. ◆ Develop protocol for high-risk youth. ◆ Demonstrate adherence to court orders. ◆ Communicate with district attorneys and public defenders.
Keeping the stakeholders informed.	◆ Track and report outcomes. ◆ Share literature. ◆ Conduct workshops.
Sharing the value base.	◆ Reinforce Wraparound values in all meetings. ◆ Conduct strength-based cross training. ◆ Include parents in joint meetings.

This model is being considered for youth coming out of State juvenile correctional facilities.

Nationally, several States and communities have incorporated aspects of the program into their own systems of care. The Center for Mental Health Services describes Wraparound Milwaukee as a most promising practice in children's mental health.

The initial results are encouraging. Wraparound Milwaukee offers an innovative and cost-effective approach and an alternative to punitive approaches to juvenile violence and delinquency.

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